TEXAS DEPARTMENT OF INSURANCE
Division of Workers' Compensation - Medical Fee Dispute Resolution (MS-48)
7551 Metro Center Drive, Suite 100, Austin, Texas 78744-1645
(512) 804-4000 | F: (512) 804-4811 | (800) 252-7031 | TDI.texas.gov | @TexasTDI

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name
Bruce Whitehead, M.D.

Respondent Name
Trumbull Insurance Company

MFDR Tracking Number
M4-15-4161-01

Carrier's Austin Representative
Box Number 47

MFDR Date Received
August 26, 2015

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "… when multiple IR's are required as a component of a DDE, the DD shall be reimbursed $50.00 for each additional IR calculation."

Amount in Dispute: $100.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "Our investigation found that reimbursement was made in accordance with Rule 134.202.

Per documentation submitted by the provider, MMI/IR exam was performed on one body area (right knee/leg), thus, additional reimbursement would not be warranted."

Response Submitted by: The Hartford

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
July 2, 2015	Designated Doctor Examination	$100.00	$0.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and applicable rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §134.204 sets out the fee guidelines for Division-specific services.
3. The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
   - P12 – Workers' compensation jurisdictional fee schedule adjustment.

- 4150 – An allowance has been paid for a designated doctor examination as outlined in 134.204(j) for attainment of maximum medical improvement. An additional allowance may be payable if a determination of the impairment caused by the compensable injury was also performed.
- 947 – Upheld no additional allowance has been recommended.

Issues

1. What is the correct rule to examine the disputed services?
2. What is the maximum allowable reimbursement (MAR) for the disputed services?
3. Is the requestor entitled to additional reimbursement?

Findings

1. The insurance carrier indicated in their position statement that payment had been made "in accordance with Rule 134.202." 28 Texas Administrative Code §134.204 (a) states, in relevant part:

   Applicability of this rule is as follows:
   (2) This section applies to workers' compensation specific codes, services and programs provided on or after March 1, 2008.
   (3) For workers' compensation specific codes, services and programs provided between August 1, 2003 and March 1, 2008, §134.202 of this title (relating to Medical Fee Guideline) applies.

   Review of the submitted documentation finds that the services in dispute occurred on July 2, 2015. Therefore, the correct rule to examine the disputed services is 28 Texas Administrative Code §134.204.

2. 28 Texas Administrative Code §134.204 (j)(4)(B) states, in relevant part, "When multiple IRs are required as a component of a designated doctor examination … the designated doctor shall … be reimbursed $50 for each additional IR calculation…" The medical report submitted with the dispute, dated July 2, 2015, page 7, finds that there are two impairment rating (IR) calculations:

   - Knee strain – 0%
   - Knee strain plus severe chondromalacia of the patella. Thinning of the hyaline cartilage of the medial femoral condyle – 0%

   Therefore, the MAR for the disputed CPT code 99456-W5-MI is $50.00.

3. The total MAR for the disputed service is $50.00. The insurance carrier paid $50.00. Therefore, no additional reimbursement is recommended.

Conclusion

For the reasons stated above, the Division finds that the requestor has not established that additional reimbursement is due. As a result, the amount ordered is $0.00.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is entitled to $0.00 reimbursement for the disputed services.

Authorized Signature

	Laurie Garnes	October 23, 2015
Signature	Medical Fee Dispute Resolution Officer	Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute has a right to seek review of this decision in accordance with 28 Texas Administrative Code §133.307, 37 *Texas Register* 3833, applicable to disputes filed on or after June 1, 2012.

A party seeking review must submit a **Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision** (form **DWC045M**) in accordance with the instructions on the form. The request must be received by the Division within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the Division using the contact information listed on the form or to the field office handling the claim.

The party seeking review of the MFDR decision shall deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §141.1(d).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.